Interior Alaska Orthopedic & Sports Medicine

Mark A. Wade, M.D.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Dr. Mark A. Wade to:

________Release information to: _______Obtain Information From:

Source: ____

Address: ____

City/State/Zip: ____

Phone#: ___________________ Fax# ___________________

Purpose of Information:

_____ Second Opinion
_____ Continue Treatment
_____ Personal Use
_____ Legal Use
_____ Other

Information Requested:

____ Progress/Chart Notes
____ Operative Notes
____ X-Ray

Patient Name: ____________________________________ Phone # ___________

Date of Birth: _____________ SSN: _____________________

Address: ____

City/State/Zip: ____

Signature: ______________________________ Date: _______________________

Faxed: ________________________________ Mailed: _____________________

Pt picked up: ______________________________ Date: _____________________

*First copy of medical records and digital x-rays are at no charge.
Any additional copies of medical records are $25.00/x-rays are $15.00.

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